PLEASANT VALLEY SCHOOL DISTRICT
Health Services Department

ASTHMA EMERGENCY CARE PLAN

Student Photo

To be completed by Parent/Guardian

Name:_____ Date of Birth:_____ Grade:_____

School:_____ Teacher:_____

Parent/Guardian Name:_____ Phone (Home/Work/Cell):_____

Parent/Guardian Name:_____ Phone (Home/Work/Cell):_____

To be completed by Health Care Provider

Health Care Provider:_____ Phone:_____

Asthma severity (circle one): Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

A completed and signed Authorization For Any Medication Taken During School Hours (SFA-5010 Rev 3/14) form for each medication prescribed on this Asthma Emergency Care Plan is on file for this school year.

1. Control medication to be taken at school:_____
2. Quick-relief medication when symptoms occur at school:_____
3. Preventive medication before exertion or exercise at school:_____

   If student requires an inhaler before exercise how many minutes before exercise:_____
4. For students on inhaled medication (all students must go to the health office for oral medications):
   ❑ Assist student with medication in health office ❑ Student may carry own inhaled medication
5. Check known triggers:

❑ Exercise	❑ Paint	❑ Grass	❑ Strong odors
❑ Cold weather	❑ Smoke	❑ Perfume	❑ Weather changes
❑ Chalk dusk	❑ Flowers	❑ Mold	❑ Food
❑ Dust Mites	❑ Bushes	❑ Animal/Birds	❑ Allergies
❑ Air Pollution	❑ Trees	❑ Pollens	❑ Other

ACTION TO TAKE	CALL 911 IF STUDENT HAS
• Stay with Student, remain calm and speak softly • Seat student in upright position • Encourage slow and deep breaths • Give quick-relief medication: shake well before each puff, give _____puffs (hold breath for 10 seconds after inhaling medication and wait 1 minute between puffs)	• Difficulty speaking • Flared or enlarged nostrils • Rapid or shallow breathing • Struggling or gasping for breath • Continuous spasmodic coughing • Skin pulling in around neck with breathing • Gray, dusky or bluish color around mouth or under finger nails

Administer CPR if Breathing Stops! Continue Until EMS Arrive!

I authorize school personnel to implement this Asthma emergency Plan as described:

_____ _____
Health Care Provider Signature Date

I give my consent for school personnel to take appropriate action for the safety and welfare of my child. I give my consent for the school nurse to communicate with the authorized health care provided when necessary.

_____ _____
Parent/Guardian Signature Date

DISTRITO ESCOLAR PLEASANT VALLEY
Departamento de Servicios de Salud

PLAN DE CUIDADO DE EMERGENCY PARA ASMA

Student Photo

Para ser llenado por un Padre/Tutor

Nombre:_____ FdeN_____ Grado:_____

Escuela_____ Maestro:_____

Nombre de Padre/Tutor:_____ Tel. (casa/trab./Cell):_____

Nombre de Madre/Tutor:_____ Tel. (casa/trab./Cell):_____

To be completed by Health Care Provider

Health Care Provider:_____ Phone:_____

Asthma severity (circle one): Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

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Administer CPR if Breathing Stops! Continue Until EMS Arrive!

Autorizo al personal escolar a implementar el Plan de Emergencia para Asma. El plan descrito:

_____ _____
Health Care Provider Signature Date

Le doy mi consentimiento al personal escolar a tomar acción apropiada para la seguridad y bienestar de mi niño. Doy mi consentimiento a la enfermera escolar para que se comunique con el proveedor de cuidado de salud autorizado cuando sea necesario.

_____ _____
Firma de uno de los padres/tutor Fecha